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ABSTRACT

The manual examines issues in determining eligibility criteria for students with serious emotional disturbance (SED). Educational and clinical definitions of SED are compared, components of the educational definiton are examined, and the issue of differentiating behavioral disorders from serious emotional disturbance is considered. The assessment process for students with SED is then delineated, including educational history; description of previous interventions; developmental and health history; teacher, child, and parent interviews; home visits; behavioral observations; language development; basic skills; and emotional functioning. A final chapter considers the use of criteria from the Diagnostic and Statistical Manual of Mental Disorders in the identification and diagnosis of SED children. Appended are a list of the agencies participating in the criteria project and a list of behavioral characteristics identified by the agencies as comprising evidence of serious emotional disturbance. (CL)

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Identification and Assessment of the Seriously Emotionally Disturbed Child

A Manual for Educational and Mental Health Professionals

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CALIFORNIA STATE DEPARTMENT OF EDUCATION
721 Capitol Mall
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Bill Honig
Superintendent
of Public Instruction

FOREWORD

The challenge of working with the seriously emotionally disturbed (SED) child has presented a variety of issues for both special educators and mental health professionals. With the passage of AB 3632, both fields are now faced with shared responsibilities and areas of concern. As the Department of Education and the Department of Mental Health work together to meet this new mandate, it is hoped that this document will provide assistance in the clarification and resolution of issues related to the identification and assessment of the SED child.

This manual represents a comprehensive collection of reference materials which Special Education Local Plan Agencies may wish to utilize as they develop guidelines and procedures for determining program eligibility criteria for this population. It is my hope that this document will assist in the delivery of programs available to SED children in California schools.

I congratulate the Department of Education's Diagnostic School in Los Angeles, the more than 80 local educational agencies participating in this manual's development and the external review committee who contributed to this publication. The Department of Education recognizes this achievement as an example of three of its primary goals - providing active leadership and direct services to its local educational agencies and assuring excellence in educational programs and practices.

Bill Honig

Superintendent of Public Instruction

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

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FOREWORD

The State Department of Mental Health is committed to providing the most comprehensive range of mental health services possible to the children and youth of California. A major thrust in the delivery of such services has been to work closely with related disciplines and professions, and particularly education, to make our efforts most effective.

With the recent signing into law of AB 3632 by Governor Deukmejian, the necessity for cooperation between mental health and educational agencies and professionals has significantly increased. This manual emphasizes how cooperation is an essential element for all professionals in working with emotionally disturbed children. I would like to commend the Children and Youth Services Bureau of Los Angeles County and the professional staff at the State Diagnostic School for Neurologically Handicapped Children, Southern California, in their efforts to develop a comprehensive guide for the identification and assessment of seriously emotionally disturbed children in the local educational setting.

This manual represents an effective tool for allowing both mental health and educational professionals to assess the emotional needs of children. It is intended to significantly increase the ability of professionals in both fields to more appropriately identify and assess this high-risk population. I sincerely believe this manual is a major step toward the unity of education and mental health professionals to more effectively meet the needs of the children and youth of our State.

Sincerely,

D. MICHAEL O'CONNOR, M.D.
Director

PREFACE

The Diagnostic School for Neurologically Handicapped Children, Southern California (DSNHC-SC) is one of six State Special Schools operated by the California State Department of Education to provide direct services to local educational agencies (LEAs) throughout California. Two primary objectives of the DSNHC-SC are to offer technical assistance to LEAs and to provide state-of-the-art assessments of students. To these ends I am most pleased that this manual has been prepared.

While the Department does not intend that this manual constitute policy, I believe it does provide the professional community serving seriously emotionally disturbed (SED) children another reference as the often complex decisions of identification and assessment are addressed. This is particularly exciting and timely as educational and mental health professionals enter the implementation phase of AB 3632.

I congratulate the authors of this manual on their outstanding efforts and successful completion of such a comprehensive document. I wish to acknowledge and commend Dr. Terry Tibbetts, whose vision, leadership and tenacity provided the basis for this publication. As a licensed clinical child psychologist at the DSNHC-SC, he has developed an impressive background in working with behaviorally disordered and emotionally disturbed children. Dr. Tibbetts also serves on the Los Angeles County Department of Mental Health planning committee for implementation of AB 3632. Mr. Tom Pike is currently employed at the DSNHC-SC as a licensed educational psychologist. He has developed a wide range of assessment and treatment skills for the behaviorally disordered and emotionally disturbed child as a member of our transdisciplinary assessment team. Ms. Nina Welch has previously served as a licensed speech and language pathologist on our transdisciplinary assessment team serving the SED population. Currently, Ms. Welch serves as an administrator at the DSNHC-SC, assisting in program development for this unique population of students. I hope the readers and users of this manual share in my enthusiasm as I congratulate these individuals for their significant contribution to the field.

Ronald S. Kadish, Ph.D.
Superintendent
DSNHC-SC

ACKNOWLEDGEMENTS

We would like to gratefully acknowledge the special efforts of Dr. Irving Berkovitz and Dr. Rose Jenkins of the Los Angeles County Department of Mental Health for their willingness to provide input and support in this project almost from its inception. Their suggestions and comments were very helpful in the development of this manual.

We would also like to acknowledge and to thank the more than eighty local educational agencies and SELPAs that provided responses to our requests for information on local identification and assessment practices for seriously emotionally disturbed children.

Additionally, we would like to express our deep gratitude to Ms. Irene Luna, who singlehandedly typed more draft versions of this manual than we care to remember. Her continued effort in this project was a major asset in its ultimate completion.

Finally, we would like to thank Dr. Ronald Kadish, Superintendent, for giving us the encouragement to proceed with this project and for allowing us sufficient time to produce a product in keeping with the high standards of the Diagnostic School for Neurologically Handicapped Children, Southern California.

We are especially grateful to the following educational and mental health professionals who generously gave of their time as reviewers to ensure the theoretical, cultural and empirical accuracy of this manual.

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INTRODUCTION

With the passage of Public Law 94-142 in 1975, children who were "seriously emotionally disturbed" (SED) could be considered eligible for special education and related services. SED was defined in regulations (34 CFR, Sec. 300.5b8) as follows:

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

(A) An inability to learn which cannot be explained by intellectual, sensory or health factors;

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

(C) Inappropriate types of behavior or feelings under normal circumstances;

(D) A general pervasive mood of unhappiness or depression; or

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

While positive in intent, the way in which the SED category was defined was neither operational nor specific, thus giving little guidance to individual states as to how they could effectively administer this category.

In California, the subsequent development of the State Master Plan for Special Education similarly failed to provide definite criteria for SED students, using instead almost identical definitions as contained in PL 94-142. Thus, wide disparities have continued to exist among local educational agencies (LEAs) as to what constitutes an SED child and how to most appropriately define the eligibility criteria. Further complicating this process, mental health providers often utilize a clinical definition of emotional disturbance that may be significantly less rigorous than the educational definition laid out by PL 94-142, thus adding to the confusion of school administrators, IEP team members and parents. Educators are additionally required under both the state and federal regulations to differentiate between children who are educationally defined as "socially maladjusted" (although they may well fit a mental health definition of seriously emotionally disturbed), as opposed to those who are considered educationally eligible for SED. At the same time, many children may show internal emotional distress with symptoms that could be classified as a "behavioral" disorder. To exclude such children could well be destructive to the educational and psychological needs of the child. LEA staff need to ensure that the child's maladaptive behaviors are not reflective of an underlying emotional disorder.

A procedural document with specific, operationally defined criteria regarding educational definitions of serious emotional disturbance, behavioral disorder and social maladjustment, as well as appropriate assessment procedures for identification of SED characteristics, would appear to meet a critical need for many California LEAs and their special education staff. It is the purpose of this handbook to provide that procedural document. Its emphasis is twofold: (a) to operationally define serious emotional disturbance and behavior disorders (including social maladjustment); and (b) to discuss ways in which thorough, comprehensive and accurate assessments of SED children can be made.

It is hoped that this handbook will be useful to LEAs, special education administrators and psychologists in California who must daily grapple with the need for definitive criteria and procedures in their efforts to determine eligibility criteria for their SED students.

CHAPTER 1

EDUCATIONAL AND CLINICAL DEFINITIONS OF SERIOUSLY EMOTIONALLY DISTURBED: A COMPARATIVE OVERVIEW

As noted, the question of definition of serious emotional disturbance continues to be debated among educators. It is not surprising to find that similar efforts to define emotional disturbance from a clinical or psychiatric perspective have encountered the same difficulties (Hallahan & Kauffman, 1982).

Part of the difficulty in clinically defining emotional disturbance lies in factors such as differences among conceptual models of emotional disturbance, difficulties in measuring and defining emotional states, variation in both normal and disturbed children's emotions and behaviors, relationships between emotional disturbance and other contributing conditions (e.g., hyperactivity, mental retardation, etc.), cultural and social expectations of behavior and the functions and roles of the labelling agents.

Distinguishing a child who is seriously emotionally disturbed from children who may be less disturbed or relatively more emotionally healthy can be difficult at times, particularly in that there is no single criterion for emotional health (Group for the Advancement of Psychiatry, 1966). Instead, emotional health involves a number of different functional abilities, encompassing but not limited to the following:

(1) Intellectual - accurate perception of reality, age-appropriate thought processes, achievement of academic success appropriate to cognitive level, ability to organize thoughts and actions to accomplish age-appropriate goals and ability to use language to express feelings.

(2) Social - adequate balance between autonomy and dependence, positive and on-going social relationships with others, and age-appropriate capacity to share and empathize with peers.

(3) Emotional - emotional stability, self-perspective, ability to delay gratification and to tolerate frustration and anxiety.

(4) Adaptive - flexible coping style, self-awareness, ability to use fantasy in play constructively and existence of a self-concept.

When a child fails to demonstrate these qualities, concern is generated regarding the emotional health of the child. However, clinicians diverge in their approaches to classifying and identifying the emotional deviance.

Rhodes and Tracy (1972) have outlined several different clinical approaches to the etiology of emotional disorders:

(1) Biological - genetic, neurological and/or biochemical factors cause disturbed behavior;

(2) Psychoanalytic - internal and unconscious dynamics are the underlying cause of emotional deviance;

(3) Humanistic - emotional disturbance springs from the child being out of touch with himself and his feelings;

(4) Ecological - poor interaction of the child with elements of the social environment creates emotional distress;

(5) Behavioral - emotional disturbance is simply the result of inappropriate learning opportunities leading to inappropriate behaviors.

Because of such diversity in the mental health field, satisfactory definitions of emotional disturbance are difficult to find. The Diagnostic and Statistical Manual of Mental Disorders, third edition (American Psychiatric Association, 1980), commonly called DSM-III, which is the primary reference source for psychiatrists and clinical psychologists, states this clearly:

> ... there is no satisfactory definition that specifies precise boundaries for the concept 'mental disorder'....

While the authors of DSM-III do not pretend to resolve this complex issue, they do state their own conceptual criteria:

> ... a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society.

This DSM-III definition avoids the necessity of having to stand behind a particular approach to mental health (note that a dysfunction can be "behavioral, psychological or biological"), and at the same time excludes social deviance as a mental disorder by requiring that the disorder be more than simply a disturbance between the individual and society.

Currently, the DSM-III definition of mental disorder is generally used by mental health professionals in the field, both because it is atheoretical with regard to etiology and also because it attempts to comprehensively describe the manifestations of various mental disturbances in a descriptive and logical manner.

Of more concern, however, is the fact that many classroom behaviors that may be negative -- but are generally not considered indicative of serious emotional disturbance -- are categorized as mental disorders under DSM-III (refer to Chapter III for a more detailed discussion of this issue). Thus, mental health professionals may identify and classify

children as emotionally disturbed who would not qualify as SED under educational criteria. Additionally, the terms "over a long period of time," "to a marked degree," and "adversely affecting educational performance," which are in the Federal definition of SED, are not uniformly considered in the DSM-III criteria when assigning diagnostic labels of emotional disturbance.

This has led to a major problem in effective communication between mental health professionals, many of whom have little background in educational programs or policies, and special education administrators and school psychologists. Oftentimes, mental health professionals may recommend to districts that a child be placed in a particular kind of educational setting based upon their emotional disturbance, but with no reference to whether the child actually qualifies as seriously emotionally disturbed under PL 94-142 (Slenkovich, 1983).

It is thus important that educational professionals keep in mind that mental health professionals may tend to view any child who demonstrates impaired functioning and/or emotional distress as a child with an emotional disturbance. Such an identification and diagnostic process requires less stringent standards than those necessary to meet SED identification criteria required under PL 94-142. As a result, many "false positives" may be encountered by LEA staff (i.e., children identified as SED who, in fact, do not fit the educational criteria for SED).

Mental health professionals and local educational agencies must work cooperatively to ensure that an identified emotional disturbance meets the three limiting criteria and five major characteristics outlined in PL 94-142. Any statements of emotional disturbance without reference to educational SED criteria will reduce the overall utility of the evaluation and may result in the child's failing to gain the educational support and assistance needed to function effectively in the educational system.

CHAPTER 2

THE EDUCATIONAL DEFINITION OF THE SERIOUSLY EMOTIONALLY DISTURBED CHILD

The definition of serious emotional disturbance as contained in the California Master Plan comes directly from PL 94-142. Each of the terms used in the SED definition has a specific meaning but, at the same time, tends to be global rather than operational in nature. Thus, specific interpretation and application of the terms used in the definition are left to the subjective judgment of local educational agency (LEA) staff. This has led to a wide variability between LEAs as to who can be considered eligible for SED services.

Further complicating the educational picture is the fact that the PL 94-142 definition represents a mixture of several different theoretical positions in order to increase its acceptability to a wide variety of professionals with differing orientations (Rich, 1982). For example, references to depression, mood and feelings have a psychodynamic association, while references to inappropriate types of behavior and inability to learn suggest a behavioral orientation. Similarly, discussion of interpersonal relationships indicates a sociological view, while referring to physical symptoms suggests a medical model. As a result, the particular criteria selected for justification of an SED placement often tend to be subjective and the product of the particular practioner's theoretical orientation. Nevertheless, it is possible to operationalize the state and federal SED definitions in a clear and comprehensive manner.

The SED educational definition consists of three major components: (a) SED as an emotional condition; (b) SED as a set of three limiting criteria, all of which must be met prior to classification; and (c) SED as a set of five characteristics, at least one of which must be met prior to classification. Each of these major components will be discussed in the following sections of this chapter.

SED AS AN EMOTIONAL CONDITION

PL 94-142 states clearly that:

> The term means a condition exhibiting one or more characteristics....

Thus, for any child to be considered for SED classification, there must be a serious emotional condition from which any behavioral or emotional characteristics stem. Isolated behaviors or expressions of emotionality per se do not constitute a serious emotional disturbance. While many handicapped children may demonstrate one or more of the characteristics outlined in the educational definition of SED, this does not automatically define them as seriously emotionally disturbed (Slenkovich, 1983).

An emotional condition is a syndrome or disturbance such as those defined under the DSM-III or the GAP report criteria (Group for the Advancement of Psychiatry, 1966). The condition should be identified prior to further consideration of SED classification for a child.*

SED AS A SET OF THREE LIMITING CRITERIA

PL 94-142 states that the characteristics of severely emotionally disturbed children must be exhibited:

> ... over a long period of time and to a marked degree, which adversely affects educational performance.

Each of these three limiting criteria - all of which must be met for any of the five SED characteristics previously noted on page 1 - can be more operationally defined.

(1) Over a Long Period of Time

A long duration of demonstrated SED characteristics is necessary in order to rule out a number of temporary adjustment reactions, such as reactions to developmental changes (e.g., puberty), or temporary reactions to marked increases in psychosocial stressors (e.g., divorce, death of a parent or sibling, etc.).

The need to establish a long period of time also provides LEA staff with the opportunity to utilize behavioral interventions in order to rule out the possibility that the child is exhibiting a behavioral disorder rather than a severe emotional disturbance.

The duration of demonstrated characteristics should be a minimum of six (6) months in length, following extensive and comprehensive efforts at behavioral intervention and change during the six-month period.

A shorter duration time may be appropriate in those few specific SED conditions explicitly noted in DSM-III as exhibiting a specific time frame shorter than six months (e.g., Major Depressive Episode). However, regardless of the time frame utilized, SED consideration should be explored only after extensive behavioral intervention has been previously undertaken.

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*Some reviewers suggested that the GAP criteria not be cited, noting both their lack of wide acceptance as well as the long interval of time since their initial publication. By contrast, Marks (1983), in her comparison of DSM-III and GAP classifications, has noted that:

> The GAP classification of disorders in children is considered more satisfactory in presenting the continuum of disturbances while acknowledging the fluidity of the evolving child's developmental process.

(2) To a Marked Degree

This limiting condition comprises two separate components, both of which must be present for the condition to be met: pervasiveness and intensity.

Pervasiveness, the continuity of the negative behaviors exhibited by the child, is a primary characteristic that distinguishes SED children from other children with behavior disorders. In contrast to the latter, who are significantly more likely to exhibit negative or inappropriate behaviors only in certain settings or with certain individuals, SED children demonstrate the characteristics of their disturbance across almost all domains (school, home, community) and with almost all individuals. Pervasiveness is easily documented through school observation, home visit, teacher and parent interviews. DSM-III (Axes IV and V) can be utilized to determine where the student has consistently and continuously demonstrated impaired functioning in the areas of social relations, school functioning and use of leisure time.

Intensity refers to the demonstration of negative behaviors in an overt, acute and observable manner. The demonstrated behaviors must produce significant distress either to the individual or to others in his environment and must be primarily related to the SED condition. Without such demonstrated behaviors, regardless of psychological or clinical test scores (which may "prove" that the child is seriously emotionally disturbed), the child does not qualify for SED classification. The child's sociocultural background should be specifically considered when evaluating this condition, particularly with reference to ritualistic behaviors or a belief in spirits.

(3) Adversely Affects Educational Performance

Most importantly, the negative behaviors of the child must be demonstrated to occur in the school setting and to result in an impairment of the child's ability to benefit from that setting. Because PL 94-142 is an educational law, the focus of classification and placement efforts is, understandably, on assisting the child to improve educational performance despite the presence of a handicapping (SED) condition. If the child is able to demonstrate progress in the regular educational program or in a "less restrictive" special educational setting, then classification of that child as SED is neither necessary nor appropriate.

There are a number of ways in which an adverse effect upon educational performance can be determined. One major way is through consideration of the child's academic achievement. Adverse educational performance can be defined as achievement that is significantly lower than one would reasonably expect for that child's level of cognitive functioning. Impact upon learning can also be demonstrated by the child's quality and degree of task completion, on-task behavior, group participation and peer-teacher interaction. Such adverse effects of the SED condition, however, should be supported by at least two separate observations by a credentialed pupil personnel services worker and/or school psychologist.

Another way often used by school districts is through documented teacher observations, work samples of the child, criterion-referenced assessment and grade reports, all of which are considered to reflect the child's level of educational functioning. Domains that should be assessed in an evaluation of educational performance can also include the areas of speech and language, fine- and gross-motor skills, self-help and life skills and social-

affective functioning. Although such a domain-specific assessment should not be used in lieu of an evaluation of academic progress, it does provide for consideration of all aspects of a child's functioning in the educational setting as they may be impacted by his emotional disturbance.

It must also be documented that the poor educational performance of the child is not due primarily to lack of attendance. Additionally, if a child's educational performance is to be compared with others, comparisons should be made only with peers of the child's socio-cultural background.

Throughout assessment of the child in this area, it must be remembered that the SED condition must be the primary disabling factor in the student's inability to benefit from the educational environment. If it is not, then the child is not an appropriate SED candidate, and other special educational classifications should be considered.

An adverse effect upon educational performance may be assumed when a child is actively dangerous to self or to others in the educational setting and the actions are not due to a behavioral disorder (e.g., violent crime, gang activity, drug usage, etc.).

SED CHARACTERISTICS

In order for a child to be classified as SED, he or she must meet all three of the limiting criteria described above and at least one of the five specific characteristics discussed below.

(1) An Inability to Learn Which Cannot Be Explained by Intellectual, Sensory or Other Health Factors

This characteristic is designed to ensure that a comprehensive and differential assessment is performed which would rule out any non-SED reasons for the child's inability to learn (adverse educational performance). It requires that a child be so severely emotionally disturbed that he or she cannot learn, despite appropriate educational interventions and the efforts of the child.

Other possible reasons for the child's inability to learn might include mental retardation, speech and language disorders, multiple handicaps, autism, hyperactivity or hearing/vision problems. Thus, a comprehensive assessment plan would include consideration of and possible formal evaluation of the child's physical health, intelligence, learning potential, speech and language abilities and social-affective functioning.

The differential assessment should also rule out motivational factors or behavioral difficulties (e.g., the student refuses to complete homework as part of a pattern of manipulative behavior), as well as social and cultural factors that may be interfering with the student's ability to learn. Non-attendance as a contributing factor must also be ruled out.

Schizophrenic symptomatology does not qualify under this SED characteristic. Schizophrenia is specifically named elsewhere in the SED regulations as a qualifying disorder. Rather, as Bower (1969), who originally proposed this characteristic, noted:

> An inability to learn is, perhaps, the single most significant characteristic of emotionally handicapped children in school.... If all other major causative factors have been ruled out, emotional conflicts or resistances can be ruled in.

Thus, the intent of this characteristic is to eliminate potential variables, other than emotional disturbance, that may be influencing the child's inability to learn. After all other possible behavioral, motivational, cognitive, cultural, sensory and other health factors have been ruled out, then emotional conflicts can be considered to exist. Remember that this characteristic must also meet all three limiting criteria in order to be considered as indicative of SED eligibility.

(2) An Inability to Build or Maintain Satisfactory Interpersonal Relationships with Peers and Teachers

Eligibility under this SED characteristic requires that the child be unable to initiate or to maintain satisfactory interpersonal relationships with peers and teachers. This inability should be primarily because of the severity of the child's emotional disturbance.

The fact that SED students may have no friends or that their behaviors result in none of the other children in the class wishing to interact with them does not necessarily make them SED-eligible under this characteristic. Bower (1969) notes that:

> It isn't getting along with others that is significant here. Satisfactory interpersonal relations refers to the ability to demonstrate sympathy and warmth towards others, the ability to stand alone when necessary, the ability to have close friends, the ability to be aggressively constructive, and the ability to enjoy working and playing with others as well as enjoying working and playing by oneself.

Eligibility under the characteristic must also address the fact that it is conjunctive: the child must show serious impairment both with peers and teachers. This impairment must also be demonstrated to be primarily related to the SED handicapping condition, and a differential diagnosis should further rule out factors such as social maladjustment, withdrawal, aggression or social immaturity as being responsible for the impairment.

It should also be emphasized that the term "inability" must be separated from the terms "unwilling" or "lacking the social skills." Many learning handicapped (LH) and severely handicapped (SH) children lack the effective social skills necessary to build satisfactory interpersonal relationships (Strain, 1982). Such a lack of social skills does not make a child eligible for SED classification under this characteristic. Similarly, many children with withdrawn behavioral disorders may be unwilling to build satisfactory interpersonal relationships despite their ability to do so.

If the child does not possess appropriate social skills, they must be systematically taught to the child (cf. Tibbetts & Long, 1982). Thus, it is important for the SED assessment to evaluate the degree of social skills possessed by the child. Cartledge and Milburn (1980) list several different ways in which social skills can be accurately assessed. Only after a systematic and consistent effort has been made to teach such skills to the child and thoroughly documented can the child be considered for SED eligibility under this characteristic.

The teacher and other school staff working with the child should be interviewed to further document and determine that the child has been unable to establish any meaningful interpersonal relationships with peers or teachers. Similarly, the child's parents should be interviewed in order to establish the absence of meaningful peer relationships in the home and community domains. If possible, an interview with the child should also be undertaken to explore the child's perceptions of an inability to make friends and to establish relationships with others.

Again, this characteristic must meet all three limiting criteria in order to be considered as indicative of SED eligibility.

(3) Inappropriate Types of Behavior or Feelings Under Normal Circumstances

This characteristic does not refer to behaviors that are generally categorized as falling within the classification of behavioral disorders. To qualify under this characteristic, the behaviors must be psychotic, overtly bizarre or potentially or actually harmful to the student or to others. Typical behaviors that would more accurately reflect this characteristic would include catastrophic reactions to everyday occurrences, self-injurious behaviors, responses to delusions, hallucinations, severe anxiety and extreme emotional lability. In determining whether this characteristic should be applied, consideration should be given to the cultural background of the student.

Again, this characteristic must meet all three limiting criteria in order to be considered as indicative of SED eligibility.

(4) A General Pervasive Mood of Unhappiness or Depression

To meet this criterion, the student must demonstrate actual, overt symptoms of depression. "Masked depression" or depressive equivalents (Twitford, 1979), depression as identified by projective or other psychological testing and/or situational (reactive) depression caused by an immediate, identifiable environmental stressor are insufficient for classification of the child as SED.

Major Depression is one of the few DSM-III categories in which the "long period of time" criterion can be considered to be less than six months. The time criterion in these cases, as identified by DSM-III, can be as short as two weeks. In determining what time period is sufficient, the psychologist must take into account the previous emotional history of the student, the age of the student, etiology of the depressive disorder and the degree and intensity of previous behavioral interventions.

Depressive symptomatology typically involves changes in four major areas: affective, motivational, physical and motor functioning and cognition. Characteristic affective symptoms can include dejection, hopelessness and/or loneliness; the individual feels little pleasure in any activities. Motivation declines during depressive episodes, and even simple activities such as eating, writing or getting dressed become overwhelming. Physical and motor functioning also is affected, with fatigue, loss of appetite, loss of sexual interests and sleep pattern disturbances. Cognitive symptoms include feelings of worthlessness and helplessness, with feelings that things will not change. Some of the typical clinical signs of depression in children can include:

(a) Poor appetite or significant weight loss - evaluate how the child looks to you, physically. Ask the child or parent about the child's appetite and what he or she likes to eat.

(b) Insomnia in some form - the child may awake early in the morning and be unable to return to sleep. Other children do not show classic early morning awakening but instead wake intermittently throughout the night. Such children are most likely to be treated symptomatically by the family pediatrician. The psychologist should ask the parents if the child is on night sedation and, if so, what the child's previous sleeping pattern was.

(c) Loss of interest in activities usually valued or enjoyed - a general feeling of apathy or dysphoria. Ask the child what he or she likes to play, general hobbies and preferred leisure activities.

(d) Impaired concentration - the child may find it difficult to keep his or her mind on school. While observing in the classroom, you may be able to view the child drifting off, either physically or during the course of conversation.

(e) Fatigue or exhaustion is commonly seen - a loss of energy, with children talking about how tired they are. Parents often present this to the psychologist as the initial problem. The psychologist should specifically inquire about this, if the parents or children do not mention this spontaneously.

(f) Feelings about the future - with older children, it is important to explore their feelings about the future, to ascertain possible feelings of hopelessness or helplessness. Such feelings of pessimism are often linked with feelings of worthlessness, guilt or dislike of self and may be linked to suicidal intent.

(g) Suicidal intent - this should <u>always</u> be explored when the child appears to be depressed. Contrary to popular folklore, asking a child about such intent does <u>not</u> put the idea into his or her head. In its mildest form, suicidal intent may appear as a feeling that life is not worth living but without any specific thoughts of killing one's self. Husain and Vandiver (1984) provide extensive information in this area, while developmental considerations of death and suicide in children are discussed by Lonetto (1980). Although depressed affect is common during adolescence, the diagnosis of a major depression is rather infrequent among adolescents (Wenar, 1982). However, it becomes ominous as a disorder that often precedes suicide.

While a suicidal act does not constitute evidence of an SED handicapping condition per se (e.g., it may be manipulative behavior as part of a severe behavioral disorder), it should immediately alert the evaluator to the possibility of the child having such a handicapping condition and should be more extensively explored with the child, including an assessment of the risk of repetition, the meaning of the attempt and the impact upon other important people in the child's life (Cooper and Wanerman, 1984).

In considering use of this SED classificational characteristic, it again must be kept in mind that all three of the limiting criteria must be met.

(5) A Tendency to Develop Physical Symptoms or Fears Associated with Personal or School Problems

This characteristic encompasses two separate categories: physical symptomatology (referred to in DSM-III as "somatoform disorders" and "psychological factors affecting physical condition"); and fears or phobias, including "school phobia," which may not be a true phobia but may rather represent school avoidance for multiple reasons.

Physical symptoms may range from headaches, stomach pains or other bodily tension to conversion disorders. In all of these syndromes, however, the physical disorder should have no demonstrated organic etiology.

Neither should the symptoms appear to be under conscious control (if so, then a behavioral disorder would appear to be more likely). Physical symptoms, by themselves, do not constitute meeting of the SED characteristic, because they do not fulfill the requirement of an established emotional disturbance (condition). Any physical symptoms, to be considered under this SED characteristic, must be linked back in a documentable manner to a specific and identifiable emotional disturbance.

Fears may range from incapacitating feelings of anxiety to specific and severe phobic reactions and panic attacks. Typically, such feelings and reactions include persistent (to a marked degree) and irrational fears of particular objects, activities, individuals or situations that result in consistent avoidance behavior or a significant rise in anxiety or panic when the object, activity, individual or situation cannot be avoided. In most cases, children can describe fears or phobias accurately but cannot give a meaningful rationale or explanation as to why they should feel this way, although they may be able to agree that their fear is out of proportion to the actual event.

Again, all three of the SED limiting criteria must be met in order for this characteristic to be considered in SED classification. In consideration of this characteristic, the school nurse should be utilized as a resource, as physical symptoms or phobias may often first be noted during physical examinations or interviews, or previous health histories may have noted this characteristic. Illness may also be correlated when school pressures occur or when a child's self confidence is threatened, and behavioral intervention may need to be considered prior to consideration of this SED characteristic.

A particular fear often encountered in children is school phobia. True school phobia (usually termed Separation Anxiety Disorder in DSM-III) clearly fits under this SED characteristic. However, it is critical that the psychologist clearly differentiate between school phobia and truancy, which is often behavioral rather than emotional. Fenelon (1983) has outlined some of the ways in which this differentiation can be addressed:

School Phobia	Truancy
Fear about school	Anger about school
Neurotic	Character disorder (behavior disorder)
Can always find at home	Never at home - out in community
Generally a good student	Generally poor student
Many excused absences	Many unexcused absences
Staff feels empathy for story	Staff feels anger/irritation for story

The characteristic of school phobia itself appears to consist of two separate and identifiable types. Kennedy (1965) has identified these as Type I (neurotic) and Type II (characterological). A list of distinguishing characteristics is included in Table 2-1. Using this typology, a child can be classified as a Type I or Type II phobic if seven of the ten listed characteristics are met.

TABLE 2-1

CHARACTERISTICS OF TYPE I AND TYPE II SCHOOL PHOBIA

	TYPE I		TYPE II
1.	The present illness is the first episode	1.	Second, third, or fourth episode
2.	Monday onset, following an illness the previous Thursday or Friday	2.	Monday onset following minor illness not a prevalent antecedent
3.	An acute onset	3.	Incipient onset
4.	Lower grades most prevalent	4.	Upper grades most prevalent
5.	Expressed concern about death	5.	Death theme not present
6.	Mother's physical health in question (actually ill or child thinks so)	6.	Health of mother not an issue
7.	Good communication between parents	7.	Poor communication between parents
8.	Mother and father well adjusted in most areas	8.	Mother shows neurotic behavior; father a character disorder
9.	Father competitive with mother in household management	9.	Father shows little interest in household or children
10.	Parents achieve understanding of dynamics easily	10.	Parents very difficult to work with

Kennedy, W.A. School phobia: Rapid treatment of fifty cases. Journal of Abnormal Psychology, 1965, 70, 285-289. Copyright 1965 by the American Psychological Association. Adapted by permission of the author.

Type II school phobia appears to have a poorer prognosis, although it is relatively more rare, and appears to be linked to emotional dysfunctioning in the parents. By contrast, Type I school phobia appears to be more amenable to treatment and behavioral intervention. Type I school phobia, then, would appear not to meet this SED characteristic unless systematic and intensive behavioral intervention was undertaken, documented and proven ineffective. Type II school phobia would appear to more clearly meet this SED characteristic, if the three limiting criteria were fully met. It should also be kept in mind that phobia may be reflective of an underlying depression, and the evaluator should probe for this possibility. For further information in this regard, the reader is referred to Kennedy (1965).

CHAPTER 3

DIFFERENTIATION OF BEHAVIORAL DISORDERS FROM SERIOUS EMOTIONAL DISTURBANCE

One of the most common and difficult problems in considering whether or not a child may be seriously emotionally disturbed is the problem of differentiating SED children from those who may be only behaviorally disordered or socially maladjusted.

While PL 94-142 does outline its definition of SED, it does not address the issue of how behavioral disorders are to be defined, except to specifically exclude children who are found to be socially maladjusted from the SED definition. Subsequently, as Kauffman (1977) has stated,

> Definition of behavior disorders is a subjective matter. There is no standard definition that is accepted by all professionals.

One approach to defining behavioral disorders, however, that has received empirical support is that of dimensional classification. Quay (1975, 1979) and others utilized a factor-analytic technique to derive four major dimensions or clusters of inter-related traits demonstrated by children with behavioral problems. Further details regarding this approach can be found in Quay (1979). These four dimensions have been delineated as follows:

(1) Conduct Disorder - children in this dimension are likely to exhibit such characteristics as aggression, destructiveness, fighting, tantrums and defiance of authority.

(2) Anxiety-Withdrawal - children in this dimension often demonstrate anxiety, fear, tension, shyness, timidity, bashfulness, and withdrawn behavior. They tend to be hypersensitive, easily hurt, self-conscious and easily embarrassed.

(3) Immaturity - children in this dimension are characterized by a poorly developed ability to respond to environmental demands, including short attention span, poor concentration, daydreaming, poor coordination, clumsiness and distractibility.

(4) Socialized Aggression - often labeled as subcultural or socialized delinquency, children in this dimension frequently associate with "bad companions," steal, belong to gangs, are truant from school and generally exhibit behavioral traits that result in violation of the law.

While all children may demonstrate some of these behaviors at some point, it is only when the child's behavior begins to fall towards the extreme end of a particular dimension that the behavior becomes symptomatic of a disordered condition.

Kauffman (1977) has described four clusters of behavioral disorders that closely match those found by Quay. He defines these as (1) Hyperactivity-Distractibility-Impulsivity; (2) Aggression; (3) Immaturity-Inadequacy-Withdrawal; and (4) Problems in Moral Development. Cameron and Mercer (1981) have outlined "behavioral clusters" which fall into four similar major categories.

The research literature thus appears to delineate four major behavioral dimensions along which the negative behavior of children can be considered. Those children who demonstrate a significant deficit or excess of such behavior can be evaluated as children with a potential behavior disorder, as distinct from children who may have serious emotional disturbance.

Special note should be made of the behavioral dimension referred to as socialized aggression (or socialized delinquency), which is often considered to be synonymous with the PL 94-142 term social maladjustment. While students exhibiting socialized aggressive behaviors are demonstrating social maladjustment, it should be kept in mind that behaviorally disturbed students exhibiting any of the four behavioral clusters can be considered to be socially maladjusted as well. In this regard, behavioral disorders are most similar to the concept or term of social deviance, which is defined in DSM-III as:

> When the disturbance is limited to a conflict between the individual and society, this may represent social deviance, which may or may not be commendable, but is not itself a mental disorder.

Further, DSM-III states that in a mental disorder:

> ... there is an inference ... that the disturbance is not only in the relationship between the individual and society.

Most behaviorally disordered students who are incorrectly identified as SED tend to fall within the behavioral dimension of socialized aggression. Typical student behaviors in this dimension may include behaviors that are highly valued within a small subgroup but not within the range of what is considered "culturally permissible" within the larger society. The child may be able to display excellent "street" skills but come into continual conflict with parents, teachers or societal agents. Children with socialized aggression, as opposed to SED children, tend to have little detectable concern over their behavior, little observable remorse or guilt and inadequate conscience development. They are often characterized by egocentricity and self-centeredness and tend to have shallow relationships with others.

As previously noted, many children may appear to demonstrate both a behavioral disorder and a concurrent serious emotional disturbance. When such an overlay is suspected, staff evaluation should ensure accurate identification of the behavioral disorder by confirmation of three additional factors:

(1) A behavior disorder is under operant control. Most behavior disordered children have understandable and environmental goals behind their behavior. In contrast to SED children, who demonstrate a general inability to control or to cope with their internal anxiety, behavior disordered children may be able to state quite clearly and openly what their behavior is designed to accomplish. A careful behavioral analysis of the child's emitted behaviors in terms of antecedents and environmental consequences can lead to a more accurate

understanding of the purposefulness of the child's behavior. A rule of thumb often cited by school staff surveyed was that the behavior of behavior disordered children was rarely unexpected or surprising, although disturbing. By contrast, the behavior of SED children most often appeared bizarre, non-goal-oriented and unpredictable.

(2) Similarly, by definition, a behavioral disorder will be responsive to behavioral intervention. Well-planned, consistent and comprehensive behavioral modification efforts by educational professionals with a background in this area will result in a significant change in the frequency and intensity of the emitted negative behaviors. Such interventions may be operant or cognitive-behavioral; or they may involve social learning. By contrast, behavioral interventions with SED children will tend to produce minimal or no behavioral changes. However, it is critical to remember that a lack of positive behavioral changes may be due to a faulty or incomplete behavioral intervention design. Careful sequential analysis should be undertaken by qualified staff prior to any implementation of behavioral techniques. Further information in this regard is contained in Sulzer-Azaroff and Mayer (1977).

(3) A behavioral disorder is situation-specific rather than pervasive. The child with a behavior disorder will tend to demonstrate markedly different responses in different situations or with different individuals. The behavioral analyst will tend to find significant differences in behavior between the home and school domains, between different teachers, in different classrooms, or across other dimensions.

Thus, while many behavior disorders may appear concurrently with a serious emotional disturbance, the behavior disorders themselves will remain predominantly responsive to these three conditions. Therefore, careful observation and recording of problem behaviors by the school psychologist or other behavioral analyst is of critical importance, as is the appropriateness and timeliness of behavioral interventions in order to ensure valid and accurate differentiation.

A fourth factor should also be considered, and that is the relative persistence of the behavior over time. Glavin (1972), among others, has noted that up to 70% of behaviorally disordered children improve their behavior over time without any formal psychological intervention or treatment. Indeed, this is in large part the rationale behind the SED requirement that the characteristics be displayed "over a long period of time." Clarizio and McCoy (1983) review research that further underscores the need for such a requirement.

Based upon the above data, it is our belief that the psychoeducational use of the term "Behavior Disorder" can be comprehensively defined as follows:

> A child can be considered to have a behavioral disorder when a consistent pattern of behaviors falls at the extreme of one or more of the following behavioral dimensions: (a) aggression; (b) hyperactive or motorically-disturbing behavior; (c) withdrawal-inadequacy; and/or (d) socialized aggression (social maladjustment), when compared to peers of the child's cultural group and developmental status. Such behavioral disorders are (1) under operant control; (2) responsive to behavioral

intervention and modification; and (3) situation-specific rather than pervasive. The intensity and frequency of such behaviors will tend to vary as a function of time and domain.

Such a definition allows us to differentiate SED children clearly and comprehensively from children who may be demonstrating behavioral disorders of mild to major severity or to distinguish behavioral from emotional components in a child who demonstrates both a behavioral disorder and a concurrent SED condition.

CHAPTER 4

THE ASSESSMENT PROCESS FOR IDENTIFICATION OF A SERIOUS EMOTIONAL DISTURBANCE

The comprehensive assessment of a child referred for possible serious emotional disturbance must assess all relevant aspects of a child's functioning (Tibbetts, 1981). In addition, all assessment materials used should meet accepted professional criteria: they must be in the child's dominant language; they must have been validated for the specific purpose for which they are being used; they must be administered by personnel who have been trained in their use and interpretation; and they must have been normed on a sample group similar to that of the child being evaluated. Additionally, it must be kept in mind that no single procedure or instrument should be used as the sole criterion for making a decision in any particular assessment domain.

Any non-biased and comprehensive assessment process for a suspected SED child must include evaluation data in the following critical areas.

EDUCATIONAL HISTORY

This should include the student's permanent record card data, including achievement levels, history of any grade-level changes or retentions, discipline records, work habits and specific learning strengths and weaknesses. Teacher comments and anecdotal statements may be helpful. Previous special programs should be noted, as well as relevant reports from teachers or support staff in those areas (e.g., bilingual education, speech therapy, tutoring, etc.). Previous referrals should be noted, as well as number of schools attended, records that previous schools may have accumulated on the child and length of attendance at schools. The absence rate of the child should also be noted.

If particular classroom management techniques have been attempted with a child at a previous educational setting, those techniques and their outcomes should be listed in this section as well, under a separate sub-heading.

DESCRIPTION OF PREVIOUS INTERVENTIONS

In order to demonstrate that the emotional disturbance exists to a marked degree and has existed over a long period of time, as well as to rule out the existence of an operant behavioral disorder, it is necessary to document previous interventions that have been undertaken. Such documentation may provide insight regarding effective interventions to use with a given student. In addition, such documentation will provide data on antecedents and consequences. This may include descriptions of interventions undertaken in the classroom, or different classroom environments or other programs within which the child has been placed, with degree of success noted. Information should include, at a minimum, the persons involved, the degree/number of contacts, lengths of trials and outcomes. Previous interventions may include, but are not limited to, the following:

(a) Specialist consultation (district counselor, school psychologist, resource teacher)

(b) Adding of appropriate support services, such as DIS psychology/ counseling, speech and language or vocational training

(c) Use of specific behavioral modification techniques with behavioral analysis approach in home and/or school setting

(d) Alternative class placements such as continuation school, minimum class day, independent study, or home teaching

(e) Administrative interventions including parent and/or family conferences, or campus management techniques, including systematic exclusion or suspension

(f) Family counseling or other non-educational agency interventions

(g) Change of placement, including change of teacher, ROP or Work Experience

(h) Other modifications to class schedule

(i) Referral to School Attendance Review Board (SARB)

(j) Intradistrict transfer

(k) Bilingual education

(l) Alternative instructional methods (tutorial program, shortened assignments, easier materials, classroom contracts, supplemental instructional programs, paraprofessional assistance, etc.)

(m) Adjustment of school day (shortened day, placement into another class, school or grade, alternative school program, etc.)

(n) Closer home/school cooperation (daily/weekly phone/written parent contacts by teacher/administrator, etc.)

(o) Use of available community agencies and services (Department of Mental Health, Regional Centers, Child Protection and Placement Services, etc.)

Remember that all interventions listed above should be fully documented and in the student's file for review by the IEP team in its consideration of a less restrictive placement. The Whittier Area Cooperative Special Education Program (WACSEP) uses a form that appears useful in this regard. A similar form is included as Table 4-1.

DEVELOPMENTAL AND HEALTH HISTORY

In many school districts, the nurse is responsible for gathering this information and ensuring that the parents provide the data needed. Special attention should be given to all of the following: developmental delays in walking, talking, fine and gross motor coordination, peer relationships and play behavior. Prenatal, delivery and postnatal difficulties or problems should be noted. A report on the current health and physical

Table 4-1

SAMPLE CHECKLIST FOR DOCUMENTING INTERVENTIONS

Examples Of Intervention Attempted	When Started (by Whom)	Extent of Intervention	Results
Reading Specialist			
DIS Psychology Services			
Resource Specialist			
Special Day Class			
Cross-age Tutor			
Outside Counseling			
Home-School Instruction-Cooperation			
Homework			
Bilingual Education			
Behavior Management Interventions			
Reading/Math Lab			
Systematic Exclusion from Classroom Activities			
Punishment			
Change of Classroom			
Suspension			
Change of School			
Conferences (as required by law plus as needed)			
Other			

condition of the child should also be included. This will eliminate the possibility that only a physical cause may be creating the educational difficulties being experienced by the child. A report on the visual and auditory acuity of the child from a physician should also be included if preliminary screening by the school nurse indicates such a need. Chronic health problems, childhood diseases, surgery and accidents should also be included in this area of the assessment report. If there has been any previous neurological difficulty, a current neurological status report should also be a part of this assessment report.

TEACHER INTERVIEW

When a child is referred to the school psychologist for possible emotional disturbance, an interview with the referring classroom teacher should immediately be arranged to discuss the child's behaviors in the classroom and playground settings. The interview should be scheduled to allow sufficient time to fully discuss all aspects of the child's behaviors. The interview should cover both the behaviors of the child and the expectations of the teacher for the child.

The teacher should be asked what specific behaviors the child demonstrates which appear to interfere with educational progress. Behaviors should be operationally defined in a descriptive and concrete manner. The period of time (duration) the behaviors are demonstrated should be elicited from the teacher, as well as the specific circumstances under which the child emits the behaviors. This includes consideration of the time of day, the specific classroom activities/ assignments, and/or the type of activity being engaged in (e.g., unstructured play time, independent work time or 1:1 interaction with the child and teacher).

Behavioral interventions previously utilized by the teacher should be reviewed and discussed. Their rationale, length of use and outcomes should all be covered in the teacher interview, as well as whether the interventions have been successful or unsuccessful, as the teacher defines the terms. The teacher's perceptions of his or her classroom structure should also be asked.

It should be noted that while the psychologist attempts to gather specific information on the behavior of the child through this process, he or she also concurrently attempts to educate the teacher by placing the questions in the context of an A-B-C (antecedent-behavior-consequence) model. Such a model takes the focus off the child as a "bad" entity and places emphasis back upon the particular behaviors that the child exhibits. It also sets the stage for further requests for behavioral observation and data collection by the teacher.

As noted above, it is also critical that the interviewing psychologist discuss with the teacher the expectations that the teacher may have for the child. It is often overlooked that teachers have an extremely difficult job - particularly special education teachers. Their understanding of the wide variety of normal or developmental behaviors may be low, or they may be requiring behaviors that are beyond the capability of the child to perform. For example, one teacher reported "disturbed" behavior on the part of some children in an RSP program. After extensive observation of the classroom interaction between the teacher and the children, the school psychologist found that the teacher gave significantly more attention to misbehaving children than to children who were engaged in on-task activities and that more than 75% of her total comments to children were, accordingly, negative. When these observations were shared with the teacher, and

behavioral consultation was subsequently offered (and accepted), the "disturbed" behaviors disappeared. Another teacher reported that one of her LH students appeared "emotionally disturbed." While the child was nine years old chronologically, his social-affective functioning level was significantly impaired to a 5-6 year level. The teacher's concern was the child's aggressive behavior on the playground. Observation revealed that the child was highly egocentric and had difficulty in waiting for his turn in an exciting turn-taking game with a large group of peers. He would begin to lose control, become aggressive and appear "disturbed." Consultation with the teacher on what to expect from a child functioning at a lower social-affective age level was undertaken. The teacher subsequently developed a more individualized playground situation for the student and his "disturbed" behaviors diminished.

Because of issues such as these, it is important that the school psychologist, prior to the teacher interview, be familiar with the results of previous psychological evaluations of the child. Particular attention should be given to the child's (a) cognitive level of functioning; (b) receptive and expressive language functioning; (c) social-affective level of functioning; (d) memory skills; and (e) attention span. Problems in any of these areas, if not recognized and understood, can create tension, anxiety and frustration for the child in the educational setting, giving the appearance of an emotional disturbance.

Through the teacher interview, the school psychologist can gain a better understanding of the child as viewed by the teacher. In conjunction with an observation of the child in the educational setting, the psychologist may be able to provide behavioral suggestions for the teacher which will eliminate the need for continuing a formal SED assessment process.

Immediately following the teacher interview, the school psychologist should write an anecdotal summary of the interview. This provides documentation that a meeting took place and outlines the outcome and future intervention plans. This also becomes a part of the comprehensive package that may be later needed for the SED classification and placement rationale.

CHILD INTERVIEW

Another critical domain for the school psychologist in the SED identification and assessment process is the interview with the child. Such interviews, however, often run into special problems because of the resistance, age or developmental maturity of the child.

Younger children are often limited in their vocabulary, pragmatic skills or expressive abilities. These children may often misunderstand what is being asked of them and may thus respond incorrectly to questions without either the psychologist or the child being aware that this is occurring. For example, they may always pick the last choice given, or answer "yes" to all questions posed to them. Other children may become irritable and negativistic because of their frustrations over not understanding or being misunderstood. It is important to recognize this factor, rather then viewing such behavior as evidence for an emotional disturbance.

Other children may demonstrate a significant degree of shyness in the interview process. This may be the result of being anxious or frightened in the interview. Other children may not possess the prerequisite social skills. Such an inability to answer questions or to play spontaneously may seriously interfere with a valid evaluation.

It should also be noted that children have a rather high plasticity of personality. As compared to adults, children have significantly less integration and internal consistency in their personality structure. For example, children may appear to contradict themselves when talking about their feelings. At one moment they may express anger towards a sibling. Minutes later, they may express feelings of affection and love and yet be unaware of their ambivalencies. Children at lower social-affective developmental levels may also have difficulty in holding more than one feeling towards a person at any given time.

It is not the purpose of this manual to provide a guideline or set of procedures for conducting the diagnostic interview with a child. The particular method by which information may be most validly obtained will vary with the particular child interviewed. Younger children may most readily give information through use of supplemental art or play activities; conversely, older children may resist such activities and prefer to engage in a board game while talking to the evaluator. Adolescents may feel that any game or other activity is condescending and wish to be treated as adults.

There are several current resources available which provide an excellent outline of how to comprehensively examine a child suspected of emotional disturbance (cf. Leff & Isaacs, 1981; Simmons, 1981). However, some general suggestions in this area are given below.

The interview should cover five major areas: appearance, behavior, affect, perception and cognition.

Appearance

The appearance and dress of the child can give clues to ego functions, such as identifications that the child appears to be making, needs for conformity or nonconformity, and the socio-economic subculture. Self-neglect should be noted, as well as whether the child appears dressed inappropriately for age or sex.

Behavior

Motor behavior may be excessive, reflecting possible anxiety or agitated depression. Motor behavior may also be subdued, reflecting depression or fatigue. Facial expressions should be noted, as should the quality of eye contact and the ability to sustain such contact. Verbal behaviors and speech should be considered, as should the quality of the interactional behaviors between the psychologist and the child. The psychologist should also be aware of the effects of the behavior of the child upon himself. This allows the psychologist to consider the probable effects of the child's behavior upon his environment, and the ways in which individuals in the environment may be likely responding to the child.

Affect

Focus should be both upon the various emotions expressed by the child during the interview as well as the feeling states associated with such expressed statements. The psychologist particularly should look for the child's adaptive use of coping mechanisms in handling emotions, ability to learn from previous experiences, and reactions to anger, frustration, boredom, success and failure. The child's feelings about school and the current educational program can be explored as well. The particular defense mechanisms used by the student to handle affect should be explored and noted, as well as whether stated feelings or affect appear inappropriate

to the thought content. Because depression in children is not easily identified and must often be inferred, particular efforts should be made to look for this in the interview. The use of fantasy can be elicted to give further insight into the feelings and concerns of the child, as well as to determine whether he or she can distinguish it from reality. For example, a common fantasy question often directed to the child is, "What would you wish for if you could have three wishes?" Often the child will wish for something to change a problem he or she currently perceives in his world (e.g., "I wish my parents wouldn't be divorced any more"). Children with high dependency needs or needs for affection may be more likely to wish for food, money or inexpensive material possessions. Often children will give common responses. This indicates that at least some of the child's thinking is in tune with his peer-group and indicates at least some reality-based linkage.

Perception

This area primarily focuses upon whether the child possesses intact perceptual processes, as necessary to accurately receive and to process information about people and the environment. The major concern in this area is the presence or absence of hallucinations. Questioning should focus on sensory experiences, the origin of which the child locates as being outside the self. The most effective way to probe in this area is simply to ask the child a direct question (e.g., "Do you ever hear voices when there is no one around you?" or "Do you see things that other people can't see?").

Cognition

There are three major components in this area. The first is cognitive functioning, which involves the child's orientation to person, place and time, the quality of memory and the degree of demonstrated insight (the child's capacity to understand and to accept responsibility for problems). The evaluator may explore the child's self-perception, awareness of behavior and awareness of how he or she manipulates the environment. The second component is thought process, in which the evaluator assesses the child's logic, associations and possible flight of ideas. The third component is thought content, which includes ideas of reference, obsessions and delusional thinking (e.g., "Everyone is talking about me").

The interview should attempt to pull together all of the information noted above in order to develop a comprehensive summary of the child's current emotional functioning. Whenever possible, historical information given by the child and relevant to the determination of an SED classification (e.g., drug/alcohol use, child abuse or neglect) should be included. No single piece of information should be used as the sole criterion in the development of findings, and it should be remembered that many "abnormal" behaviors may occur transiently in normal children who are experiencing problems that are acute and situational rather than indicative of deep-seated emotional disturbance. It should be similarly remembered that behaviors which appear normal at one developmental level may be considered abnormal at another level.

The psychologist, after finishing the student interview, should immediately write a summary of the interview and keep this with the other materials on the child. These should become a part of the identification packet, and a summary of the interview should be included in the final assessment report.

PARENT INTERVIEW

The parent interview provides an opportunity for the psychologist to obtain additional data about the behavior of the child in the natural environment and away from the school setting. These data can then be compared to data collected in the school setting.

A family history should be gathered from the parents. This history should be as complete as possible inasmuch as some events may have clinical significance (e.g., loss of a mother in females below 11 years of age appears to contribute to later development of depressive illness). The educational background and occupational history of the parents should be obtained, as well as potentially significant factors such as parental violence, excessive drinking, criminal activity, parental absence for extended periods, inconsistent attitudes or excessive leniency/punitiveness. Any psychiatric illnesses or hospitalizations should be elicited and diagnoses obtained. Always ask the nature of the symptoms, the duration, the type of treatment and the outcome.

The parents should also be asked for a child history and general background information on their child. Included should be attitudes towards the pregnancy, its effect upon the marital relationship, early developmental milestones, sleeping or eating disorders, and relationships with siblings. If the child is beyond latency age, issues of sexual adjustment should also be explored, such as age of sexual awareness, interest in the opposite sex, sense of sexual identity and maturity of overall sexual behavior.

Any previous psychological or psychiatric history of the child should be noted, with emphasis on any past suicidal behaviors and the outcome. Past police or other law-enforcement contact should be elicited from the parents.

Throughout the interview, remember that parent accounts are inevitably influenced by their emotional attitudes towards their child. Additionally, parents' complaints about their children may largely reflect their own psychopathology or difficulties in the marital relationship. This should be kept in mind particularly when there are several children in the family, only one of whom appears to demonstrate the identified problem behavior. In the parent interview, one should be assessing the mental health of the parents and their quality of married life as well as the mental health of the child.

If possible, some time should be spent with the parents and child together. The parents should discuss the child's behavior openly and clearly in front of the child. The child should be asked if he or she agrees or disagrees with each of the statements as the parents make them. This process allows the evaluator to observe the dynamics between the parents and the child in as natural a setting as possible.

HOME VISIT

One of the key differences between diagnosis of a severe emotional disturbance as contrasted to a behavioral disorder is the concept of "marked degree." Thus, the inappropriate or negative behaviors should be seen across a wide variety of environmental domains rather than in only one or a limited number of settings. This can be partly corroborated through measures of adaptive behavior as well as classroom observations. However, another important source of data in any evaluation for possible SED classification is the home visit, assuming parental permission for such a visit can be obtained.

The home visit is an opportunity to view many important dynamics that might not otherwise be seen in a typical school setting. It allows one to see how the child typically interacts with family members and others in his natural environment and provides a richer setting for determining the relative intensity and pervasiveness of the student's behavioral/emotional disturbance.

The home visit should be written up in an anecdotal form and kept with the child's psychological records. A summary of the home visit report can be placed in the child's psychological report. The home visit report should include the following areas:

- Are the child's interactions with the parents positive or negative? Do the child's behaviors appear to confirm school staff and/or parent statements?

- What is the quality of the child's interaction with siblings and/or neighborhood peers? Are these interactions similar/different than the quality of the child's social interactions at school? Are there differences in the quality of interaction between older/younger siblings or male/female siblings and neighborhood peers?

- How does the child spend unstructured time? How does the child handle frustration and/or anxiety in the home setting? In the play setting?

- When possible, point out to the parents, in a non-threatening manner, behavioral sequences of which they may be unaware. For example, the child may have a temper tantrum during your visitation which the parents view as unprovoked. Sequential analysis, however, may reveal that the child's tantrum is the result of frustration, a desire for attention, or a wish to communicate.

- In a non-threatening manner, point out discrepancies observed (if any) between the child's home behavior and statements previously made by the parents. Do the parents respond appropriately or defensively? Are the child's behaviors rationalized or explained away? Do the parents appear to have an investment in viewing the child as the problem, regardless of the facts?

- What is the attitude of the child towards the evaluator's presence in the home?

Make sure that all observations and conclusions are behaviorally based. Avoid making assumptions or other statements that cannot be operationally supported.

When the child is culturally different, the home visit should also include a determination concerning the effects of environmental, cultural or economic disadvantage.

It is helpful to know also if the child has any family responsibilities. For older children, ask about part-time or summer employment. How does the child get to and from school and social events? Can the child do so appropriately alone and/or with peers, or does the child need adult supervision? Can the child drive the family car or take public transportation, or does he or she need adult supervision?

Keep in mind that this anecdotal report is "privileged" only if kept in a personal file with no copies distributed to other staff members. If it may possibly be needed to substantiate a disputed SED classification, be sure that all clinical conclusions are backed up with as many specific examples as possible that illustrate the point.

OTHER BEHAVIORAL OBSERVATIONS

An important part of the evaluation and assessment process is the observation of the child in the classroom setting. The psychologist can observe and differentiate behavior which appears environmentally based and situation-specific (behavior which has clear goals in mind, initiated in a manipulative manner) from behavior which appears more internally based and pervasive (behavior which appears to be less operant in nature). Again, the psychologist should utilize the A-B-C model in observations, seeking to identify both the antecedents and the consequences that follow the identified problem behavior(s).

The psychologist, in the classroom observation, has the luxury of not being continuously involved with 10-20 other students and can often see behavioral chains or other dynamics that the teacher may be unable to view. While observing, the psychologist asks the same questions posed to the teacher in the teacher interview. (a) What specific behaviors does this child demonstrate which interfere with educational performance? (b) What behaviors appear to trigger these behaviors and what are the consequences? (c) For what period of time are the behaviors demonstrated? (d) Under what circumstances? (e) Do teacher interventions appear effective/ineffective, and why?

The psychologist should vary observations to get as wide a range of behavior samples as possible. While there is no established time-length for an observation period, each should last, in general, a minimum of 20 minutes. The time of day for samples should be varied (morning, recess, lunch, afternoon). The day of the week should be similarly varied. Periods of particular difficulty should be observed (academics, transitional periods, language, pull-out, etc.) Table 4-2 gives an example of a behavioral check-list that may be useful in such observations.

After each observation session, the psychologist should write a summary of the observation, with behavioral/operant data included, and place it in the child's file. There should be at least four to five observations made of the child.

Some behavioral surveys that appear particularly helpful in keeping observational data on potential severely emotionally disturbed (SED) children include:

Behavior Evaluation Scale - a relatively new instrument, the BES yields relevant behavioral information about students, regardless of the primary handicapping condition. Its particular utility stems from its placing of all 52 items into one of the five PL 94-142 SED criteria, with a relative ranking, thus giving a general overview of how a child's particular behavioral difficulties may break down by criteria. While its validity is not conclusively established, it appears to be particularly useful in the documentation process needed for eligibility, placement and programming for SED children.

Devereaux Elementary School Rating Scale - an instrument with an extensive history which is particularly helpful in identifying behavior factors which correspond to the clusters of behavior disorders previously discussed in this manual.

Burks' Behavior Rating Scales - a more general behavior rating scale which ranges from categories assessing academics to categories which appear to examine behavior disorders (e.g. "poor attention," "excessive aggression") to categories which appear to assess more emotionally-based disorders (e.g., "poor reality contact," "poor ego strength").

TABLE 4-2

A SAMPLE BEHAVIORAL CHECKLIST FOR A CHILD

Time: _____

Day: _____

	Gets out of Seat	Yells to Others	Lack of Attention	Argues	Refuses	Fights	Lies	Complains	Needs Reminders	Needs Adult Attention	Cries	Swearing	TOTAL
Walking to Class													
Teacher Explains Schedule for the Day													
Silent Reading Time													
1:1 Tutorial Work													
Transition to Reading Group													
Reading Group													
Transition to Free Play													
Free Play													
Transition to Independent Seat Work													
Independent Seat Work													
Line Up for Recess													
Recess													
Line Up to Return to Class													
Cooperative Work with Other Students in Class													
Transition to Learning Centers													
Learning Centers													
Line Up for Lunch													
Walking to Lunch													
Lunch													
TOTAL													

To ensure comprehensiveness in this domain, the psychologist should obtain both (a) observed behaviors and their frequency in the classroom and (b) at least one behavior rating scale completed by adults across at least two different settings.

INTELLECTUAL ABILITY

Assessment of intellectual ability should utilize instruments that are appropriate in terms of language and handicapping conditions. All testing should be administered to the child in the language which is most familiar to him and which he or she can most readily understand.* Further, such children should be assessed only by individuals who are competent in both the oral and written skills of the child's primary language and who have a knowledge and understanding of the cultural and ethnic background of the child. The means by which the child's primary language is determined, as well as the degree of proficiency demonstrated by the child in his primary language, should be documented. If an interpreter is used, the assessment report should document this condition and note that the validity of the intellectual assessment may have been affected.

If there is any suspicion that the child may have difficulties with language, more than one intelligence test should be given. In such cases, a test such as the Kaufman Assessment Battery for Children (K-ABC), Wechsler Intelligence Scale for Children, Revised (WISC-R) or Stanford-Binet is usually given first, with a relatively nonverbal intelligence test such as the Leiter or Columbia Mental Maturity Scale (CMMS) given as a supplementary test. It should be noted that most of these tests have no specific norms for distinct linguistic or cultural groups, and interpretation of such tests should accordingly be done with caution.

Of particular importance in SED assessment is the differentiation of innate cognitive limitations from emotionally bound cognitive impairments. Information in this area can be gathered in a number of ways. The child's style of thinking can be observed, as can the child's responses to the problem-solving process, motivational level across different modes and types of problems, and work habits. The child's reaction to failure and capacity for self-monitoring can all be noted by the evaluator during the intellectual assessment. Wenar (1982) gives more information in this regard.

It is also important to "test the limits" with the child to determine whether the child can accurately respond to the intent of the questions asked. While such responses will not be reflected on the final test score, oftentimes such a process will give the psychologist insight into why the child may be unable to answer the questions and what type of reasoning process the child used to give the answers. Going beyond the child's specific answers by questioning the reasoning process will allow a much greater depth of understanding as to the child's cognitive processing.

Similarly, a developmental assessment of the child's cognitive skills may offer a clearer understanding of the overall functioning level of the child. Piagetian or other similar instruments may be particularly useful in attempting to determine how severely a child

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*Language proficiency in the primary language should be assessed by speech and language and hearing specialists and the results shared with other assessment staff.

may be delayed in cognitive or emotional factors and how the classroom teacher can individualize the child's educational program most effectively (cf. Fogelman, 1970; Formanek and Gurian, 1976).

Such developmental cognitive assessment involves exploring how the child organizes experiences when presented with a series of tasks. The way in which the child typically processes such tasks provides a comprehensive overview of how he or she tends to perceive the educational curriculum. As the child progresses cognitively, he or she is able to acquire more complex skills. Such an approach is more helpful to teachers than a simple IQ score in finding and developing appropriate curriculum and teaching materials for special education children.

An assessment of cognitive development, when completed, may result in a more appropriate individualized educational plan for a child, and reduce many of the negative behaviors caused by work activities that were too high, too frustrating or inappropriate for the child.

LANGUAGE DEVELOPMENT

This domain may be critical when there is a need to distinguish children who are not learning in the classroom because of language delays, deficits, or limited proficiency in English from children who are not learning because of emotional disturbance. In these cases, it is extremely important that both the psychologist and the speech and language specialist work together and integrate their findings in order to make an accurate differential diagnosis in this area.

Minimally, language development should be tested in the following areas:

Phonology

This area primarily deals with the formation and production of speech sounds and the elements of speaking. Since speech is a dynamic process, it is important that the assessment consider production of speech sounds in isolation and the manner in which these speech sounds are blended into complex patterns of connected speech. A speech analysis is the best technique to examine the production of phonemes in ongoing speech. Errors in articulation are commonly classified as being one of four types: substitution, omission, distortion and addition. SED children who do not possess a specific articulation disability may demonstrate a breakdown in articulatory skills during highly anxious situations.

Auditory processing

This is a somewhat ambiguous term which attempts to encompass a variety of auditory skills considered to have an effect on language proficiency. In this assessment, it is important to determine the basis for a child's problems in processing auditory information. Auditory skills assessed may include short- and long-term auditory memory, word retrieval, and auditory discrimination abilities. Many SED children appear to have difficulty processing information. Such difficulty may be due more to selective ability to receive external information or to unavailability rather than to a specific language processing disability.

Semantics

Generally speaking, semantics refers to the meanings of words. A competent communicator must possess not only a knowledge of single words but also the various connotations that a word might imply. Since words have multiple meanings which can change depending on the context in which they are used, a competent communicator must be able to quickly shift among word meanings in order to retrieve the appropriate label. Assessing a child's knowledge of semantics is a very complex process. Wiig and Semel (1980) suggest that assessment in this area should minimally include examining the following:

(a) A child's knowledge of single word meanings through picture identification tasks or labeling tasks (receptive and expressive vocabulary tests)

(b) A child's ability to comprehend that words can represent more than just a label for a object or instance and the ability to understand the semantic relationships among words (word definitions)

(c) A child's knowledge of antonyms and verbal reciprocity (opposites, analogies, association tasks)

(d) A child's knowledge of "inclusion of word meanings" (similarities, differences)

(e) A child's knowledge of specific relational terms for spatial and temporal relations among words, phrases and clauses

(f) A child's ability to integrate meaning across phrases, clauses and sentences (verbal absurdities)

SED children may appear garrulous and glib. Their language is often characterized by disorganization, topical discontinuity, hesitancy and perseveration. However, psychologists must be cautioned against presuming a child is SED based upon the child's bizarre speaking style. Language disabled children with semantic deficits may possess similar language traits.

Morphology and Syntax

Morphology refers to the word endings that alter a base word to create new words. The morphological elements also help to dictate and define word order (syntax). An assessment in this area should determine whether a child has a true knowledge of grammatical structures or just a rote learning of some structural forms. Children with auditory processing deficits may have difficulty in this area because of their inability to process spoken words clearly enough to master the grammatical rules.

To assess whether a child has acquired the word (morphology) and sentence (syntax) formation rules, a variety of receptive tests are available. A free speech analysis or language sample could also be used to assess a child's knowledge and use of grammatical rules. A language sample should reflect the child's language over a period of time and within various contexts. Since emotional state may influence the surface structure of sentences and the degree of structural and topical elaboration, many SED children reflect difficulties in this area. One would want to examine whether there are any significant changes in a child's communication style across all

environments with a variety of people. Unlike children with a specific language disability, SED children will usually demonstrate an increase in language proficiency when anxiety is reduced. That is, there appears to be a lot more variability in the speech and language abilities of a SED child as opposed to a child with specific language disabilities.

Pragmatics

The pragmatic aspect of language involves the child's ability to use language to communicate intent and to use language functionally within a social context. An assessment should examine the child's ability to use language for a variety of functions:

(a) Instrumental- To satisfy child's material needs in terms of goods or services (I want)

(b) Regulatory- To exert control over the behavior of others (Do as I tell you)

(c) Interactional- To establish and maintain contact with those that matter

(d) Personal- To express child's own individuality and self awareness (Here I come)

(e) Heuristic- To ask about the environment (Tell me why)

(f) Imaginative- To play act or pretend

(g) Informative- To communicate experience not shared by the listener (I've got something to tell you) (Halliday, 1975). For SED children, this is a crucial area and one in which they are often severely deficient.

Overall, it should be noted that children with serious emotional disturbances often display a wide range of communication disorders, many of which are atypical (these may be exhibited not only in the areas previously discussed but also in speech rate, rhythm, vocal pitch and loudness). The SED child's language is usually more deviant than delayed and reflects psychological disorganization. Although the child's language may show some characteristics of a semantic word disorder, these language problems are usually more related to pragmatic skills (product) than to semantic skills (content).

At the same time, the psychologist should be aware that recent research findings suggest that language disordered children may be at high risk for the development of emotional disturbance (Cantwell & Baker, 1977; Cantwell, Baker & Mattison, 1979). Thus, even if a particular child with language disturbance is found ineligible for SED classification, the psychologist should continue to monitor the child's behavioral and emotional status over a continued period of time to ensure that there is no subsequent deterioration in functioning.

ADAPTIVE BEHAVIOR

Adaptive behavior refers to the ability of children to perform the social roles considered appropriate for their age and sex, in accordance with the expectations of their social system (Carder, 1981). Under this definition, behavior is adaptive or maladaptive only in relation to the demands of a particular social system and/or situation in which the

behavior takes place. For example, a child who is passive and who shows few or no exploratory behaviors may have difficulty in the educational setting but may need these types of traits to survive in a rigid and punishing family structure. A child who is labeled as "hyperactive" by the school may be able to care for two younger siblings in an effective mature manner while the mother works at night. Adaptive behavior assessment allows a comparison of school behaviors with home and play behaviors and thus prevents unnecessary inaccuracies which might color judgment, resulting in an inappropriate identification of a child as emotionally disturbed.

If a child can demonstrate normal, age-appropriate behavior in coping with the demands of the environment when not in the classroom, it is doubtful that special education (SED) services are needed. A careful use of classroom management techniques will be most useful with such a child; alternately, intervention may be directed at environmental modifications, or a combination of the two.

There are a number of adaptive behavior measures available for use in assessing the child. Most widely used are the Vineland and the AAMD measures. The Adaptive Behavior Inventory for Children (ABIC) from the System Of Multi-Pluralistic Assessment (SOMPA) and the Social and Prevocational Information Battery (SPIB) are also seeing increased use in the educational setting. Those wishing more information on adaptive behavior and adaptive behavior measures are referred to Carder (1981).

ASSESSMENT OF BASIC SKILLS

The findings of the student's current level of academic functioning should be a central part of the assessment report. These should include the current reading level of the student, current mathematics achievement level and current language development level. The type of classroom materials being used with the child in each area should also be specified.

Current achievement levels as indicated both by teacher report with classroom materials and by the psychologist through standardized tests of achievement should be noted. Grade-level equivalents should not be reported, as they are arbitrary, and warned against in both the Peabody Individual Achievement Test (PIAT) and Wide Range Achievement Test (WRAT) manuals.

It should be kept in mind that the WRAT and PIAT are screening instruments rather than diagnostic instruments. If a child is to be considered for SED placement, WRAT and PIAT test scores are not sufficient for demonstration of an "adverse effect upon educational performance." Rather, specific diagnostic instruments such as the Sucher-Allred, Spache or Gilmore (reading) or Key Math (mathematics) should be administered.

EMOTIONAL FUNCTIONING

When assessing a child for possible identification and placement, it is crucial to assess the level and quality of emotional functioning of the child. Significant information in this area can be obtained through teacher and parent interviews, behavioral observations and the individual child clinical interview. However, additional diagnostic assessment should be obtained through the use of clinical instruments, with all relevant information then

compared and integrated. A comprehensive clinical evaluation should utilize test materials from each of the following areas:

Projective Instruments

Projective instruments require the child to utilize his or her own experiences, intellectual resources and emotional state in order to structure responses to ambiguous stimuli. Such instruments are useful in assessing the degree of the child's environmental dependency, quality of reality-testing, level of intellectual and emotional integration, emotional lability and clarity of thinking. Some of the more widely used projectives are noted below.

Rorschach: This instrument requires the child to describe what he or she perceives in a series of ten inkblots of varying designs and colors. The child's emotional level of functioning is assessed through formal analysis of different aspects of the child's responses.

Thematic Apperception Test (TAT): An instrument in which the child responds to ambiguous pictures by telling stories about the characters in the pictures. Responses are thought to be indicative of the central problems, issues and unresolved emotional conflicts in the child's life.

Children's Apperception Test (CAT): The CAT is similar to the TAT except that drawings of animals are substituted for people and there are fewer total cards. The rationale for use of the CAT is based upon research suggesting that children may be less defensive in their responses to pictures of animals as opposed to people.

Educational Apperception Test (EAT): The EAT utilizes a series of pictures of children of the same sex as the examinee, all of which depict typical school situations. This test is designed primarily to elicit feelings, issues and attitudes which may be influencing the child's behaviors in the school setting. It is a particularly useful tool for eliciting specifics with children who demonstrate anxiety regarding the school setting or "school phobia."

Roberts Apperception Test for Children (RATC): In this instrument the possible responses of children can be profiled against a standardized sample for comparison. Consisting of 16 drawings of home, school and community situations primarily involving children of the same sex as the examinee, its norming makes it particularly attractive in situations involving the possibility of due process hearings. While it should be noted that further norming of the RATC to utilize a wider range of ethnic and cultural populations is in process, it is perhaps the most easily administered and interpreted projective instrument currently available for use by school psychologists.

Hand Test: This instrument requires the child to describe what nine different drawings of hand gestures might be doing and to imagine and describe a hand gesture on a tenth (blank) card. This test is considered to be useful in predicting aggressive acting-out tendencies of the child.

Projective Drawings

Extensive research has found that drawings of emotionally disturbed children tend to differ from drawings made by children who are more well-adjusted (cf. Dileo, 1973; Klepsch & Logie, 1982). This has led to the inclusion of human figure and other drawings in the clinical evaluation of SED children. Some of the more widely used projective techniques include:

House-Tree-Person (HTP): The child is asked to draw a house, a tree and a person on blank pieces of paper. Clinical interpretations of these drawings are then made.

Draw-A-Person (DAP): The child is asked to draw a person. The examiner then interprets the child's drawings in terms of self-image and self-concept.

Kinetic Family Drawing (KFD): The child is asked to draw the members of his family doing something. Not only does this give clinical information concerning the child's relationship with family members, but it is hypothesized that the addition of movement to drawing assists in revealing the child's feelings about interpersonal relationships as well as self-concept.

Self-Esteem

There are a variety of inventories and measurement instruments used in this clinical area. Validity and reliability coefficients vary widely, and the evaluator should carefully review the manuals for those instruments being considered for use prior to administration. Some instruments in this area that have been used successfully with children are listed below:

Culture-Free Self-Esteem Inventory: This is particularly useful for upper-primary and intermediate school children, and the inventory scoring gives a breakdown of different domains of self-esteem (i.e., family, school, social and personal) as well as an informal lie scale.

Primary Self-Esteem Inventory: This inventory appears to be useful for younger children, particularly in its use of clear, large pictures which in assist the child to verbalize his or her answers.

Inferred Self-Concept Scale: Parents and teachers can provide estimates of the child's level of self-concept through completion of this instrument. This scale provides a more comprehensive evaluation of the child's self-concept levels when completed in conjunction with the administration of one of the other instruments listed above.

Objective Instruments

Objective testing involves the child responding to questions that typically involve a standardized pencil-and-paper format. The child's responses are compared with a normed sample of peers to determine the degree and quality of the child's emotional functioning.

Minnesota Multiphasic Personality Inventory (MMPI): The most popular objective instrument for gathering clinical data on children, the MMPI asks the

child to respond in a true-false format to an extensive number of statements about himself or herself. The results, when profiled, give a useful indication of child's personality style and possible difficulties in emotional functioning. This test is most validly used with children over 13 years of age.

Personality Inventory for Children (PIC): This standardized instrument is very similar to the MMPI except that it is completed by the parents regarding their child. This has the advantage of allowing objective personality information to be gathered on children as young as five years of age but has the disadvantage of potential validity problems with parents who may have a limited perspective of their children's problems.

There are many additional clinical tests, both projective and objective, that may be added to the list of test instruments noted above depending upon the particular dynamics of the child and the professional preference of the examiner. It should be kept in mind, however, that to obtain valid results with any instrument of emotional functioning, the examiner must have adequate training in emotional development and pathology of the child as well as in the administration and interpretation of the specific clinical instruments used.*

SUPPLEMENTAL ASSESSMENT AREAS

There are three additional areas that may be included in the assessment report. While not as critical as the thirteen areas discussed in the previous section, they nevertheless can serve as a source of confirmation and support for the decision as to whether SED classification is in the best interests of the child.

Private Evaluation with DSM-III Diagnosis

A DSM-III diagnosis by itself does not provide prima facie evidence of a serious emotional disorder (refer to next chapter). Nevertheless, an evaluation undertaken by a private child psychiatrist or clinical child psychologist can provide independent confirmation of the existence of emotional disturbance in a student under consideration for SED classification and placement under PL 94-142 parameters.

Axes II through V of the multiaxial DSM-III diagnosis may be of particular assistance to the assessing psychologist and the IEP team in determining the intensity, duration and pervasiveness of the emotional disturbance shown by the child. Thus, any private mental health reports available on the child should be considered as adjunctive, but not primary, evidence regarding the emotional status of the child.

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*Several reviewers underscored the importance of this statement, indicating that in their experience LEAs often tend to discourage the use of projective testing by their staff because of its clinical nature and the extensive degree of expertise required. In cases where projective testing is considered necessary such LEAs prefer to utilize outside clinical consultants or obtain assistance from county mental health services.

Previous Contacts with Outside Agencies

Oftentimes, the child may have had previous contacts with community agencies, with records and reports of the child's contacts remaining on file. If the parents agree to waive confidentiality, a review of such records can be enormously helpful in gaining a better understanding of the child's emotional dynamics and can be particularly useful in documenting the key PL 94-142 criteria of "over a long period of time."

Agencies which are most likely to have had previous contact with the child are those found in the community mental health and the local law-enforcement systems. When interviewing the parents, therefore, care should be taken to ascertain whether the child has, in fact, had previous contact with these systems. If so, a waiver of confidentiality should be sought. This also holds for contact with local Regional Centers, which may have records or materials going back historically a significant amount of time (which again will be helpful in documenting the duration of the emotional disorder).

Classroom Interventions Undertaken as a Part of the Assessment Process

A highly useful method for differentiating behavior disordered from SED children involves educational intervention in a classroom setting to determine whether problem behaviors are operantly controlled, situation-specific and responsive to intervention. Most diagnostic classroom interventions can be classified into one of three major categories: accommodations made to the student; social-cognitive interventions; and operant interventions (behavioral modification).

Accommodations: In general, accommodations consist of ways in which adults can modify the child's environment or their own behavior in an effort to change the antecedent conditions which may function as a discriminative stimulus for the child's problem behaviors. Accommodations may be of three types. Auditory-verbal accommodations can be made with students who appear to have difficulty in attending to and processing these types of information. Examples of such accommodations would include cueing, response priming and reducing amounts of information given. Visual accommodations would include such things as cueing to specific stimulus, reducing visual distractions, using a carrel and clearing of the student's desk. Environmental accommodations would include re-organizing the classroom environment to emphasize success and to provide structure to the child. Some examples of this would include clearly separating work and play areas, using consistent and predictable classroom routine, providing success level work and immediate re-direction to task.

Social-Cognitive Interventions: These interventions are designed to improve behavior through the use of specific techniques which focus upon children's ability to change their behavior through the teaching or training of specific cognitive or social skills which allow them to demonstrate more appropriate and/or positive behavior for which they can then be rewarded and reinforced. Some typical examples of social-cognitive interventions include inventory of strengths and similar self-esteem building activities, relaxation training, social skills training, assertiveness training and cognitive behavioral modification (self-modification).

Operant Interventions: Perhaps the most widely used method of intervention in the classroom environment is through the use of behavioral techniques. There are a number of different ways in which educational staff can intervene using this category of interventions. Table 4-3 provides a comprehensive guide to the most effective use of such operants. Those staff wishing a more thorough review are referred to Algozzine (1982) and Sulzer-Azaroff and Mayer (1977).

Table 4-3

GUIDE TO THE USE OF OPERANT INTERVENTIONS

	GENERAL SOCIAL IMMATURITY	SOCIALLY DEFIANT	SOCIALIZED DELINQUENT	IMPULSIVE/ HYPERACTIVE
ACTIVITY REINFORCERS	1	1	1	1
CHANGING ANTECEDENT ENVIRONMENT (Accommodations)	1	2	3	1
CHANGING SCHEDULES OF REINFORCEMENT	1	1	1	1
CONTINGENCY CONTRACTING	2	2	2	2
EXTINCTION/IGNORING	1	3	3	3
FADING	1	1	1	1
GROUP CONTINGENCIES	1	3	3	3
MODELLING	2	2	2	2
PRAISE	1	3	3	3
PUNISHMENT	1	3	3	3
REINFORCEMENT (DRO, DLO)	1	1	1	1
SELF-CONTROL (Cognitive-Social)		1	1	1
SETTING RULES	1	3	3	3
SHAPING	1	1	1	1
TOKEN SYSTEM	1	2	1	2

Adapted from Cameron, C.T., & Mercer, C.D. "Behavioral Management." In Childhood Behavior Disorders. Algozzine, R., Schmid, R., & Mercer, C.D. (eds.), 1981. With permission by Aspen Systems Corporation.

KEY: 1 - Very Useful
2 - Moderately Useful
3 - Somewhat Useful

CHAPTER 5

THE USE OF DSM-III IN THE IDENTIFICATION AND DIAGNOSIS OF SERIOUSLY EMOTIONALLY DISTURBED AS DEFINED BY PL 94-142

Oftentimes, a child who is being considered as eligible for placement in special education services under the SED classification has had previous psychological or psychiatric evaluation. As part of such an evaluation, a psychiatric diagnosis is often given to the child. Such diagnoses are typically taken from the Diagnostic and Statistical Manual of Mental Disorders (3rd edition) - DSM-III - developed by the American Psychiatric Association.

Such a diagnostic process has many benefits for professional mental health staff who may work with the child in a clinic or hospital setting. It assumes that there is a relationship between diagnosis and treatment and that the most accurate diagnosis is therefore suggestive of the most effective treatment. The DSM-III classification system also provides a common language which allows professional staff to communicate clearly about the symptomatology exhibited by the child.

However, such diagnoses are of little assistance to the school psychologist or IEP team members in attempting to determine whether a particular child meets the PL 94-142 criteria under which he or she can be classified as SED. Despite the statements of isolated professionals, there are no disorders or DSM-III diagnoses, with the single exception of schizophrenia, which will automatically qualify a child as SED for educational purposes. While the DSM-III diagnosis can be a significant part of determining the presence of an emotional condition, it does not address itself to the question of psychoeducational SED criteria, nor was it designed with this in mind.

Further, there appears little more empirical justification for the DSM-III classification system than there was for the first DSM classification system developed more than 30 years ago (Gibbs, 1982). In an effort to examine the reliability of the current DSM-III classification system, Cantwell and his colleagues (1979) sought to explore the degree of interjudge agreement in regard to diagnostic judgments regarding children. They found that:

> The average interjudge agreement was 57 percent for DSM-II, and 54 percent for Axis I of DSM-III.*

*Axis I of the DSM-III classification system includes the major clinical syndromes, such as mental retardation, conduct disorders, infantile autism, anxiety disorders and eating disorders.

The conclusion reached was that there was little increase in reliability based upon use of the DSM-III system (Cantwell, Mattison, Russell & Will, 1979). Such findings underscore the necessity for IEP team members to consider carefully all relevant factors involved in each child's individual case.

Not only do mental health professionals show a lack of consistent agreement with each others' diagnostic findings, but their own individual judgments of the same data can be inconsistent as well. Freeman (1971), using the DSM-II classification system, found that only 72 percent of child psychiatrists sampled showed agreement between diagnoses made from case history materials and diagnoses made from the same identical case history materials presented to them three months later.

The DSM-III classification system can, however, provide useful information to the IEP team in its efforts to educationally classify a child appropriately. Review of the Cantwell et al. study (1979) did indicate that:

> ... the studies involving child cases suggest that moderate to high levels of agreement can be obtained between clinicians using Axes II through V of the (DSM-III) multi-axial system, providing some evidence of the usefulness of this approach. Findings with regard to Axis I judgments are more disappointing, however (Schwartz & Johnson, 1981).

Axes II through V of the DSM-III classification system are also more useful to school psychologists and IEP team members because of their clear connection to the PL 94-142 educational criteria for SED.

Axis II is used to define specific developmental disorders such as reading, arithmetic, language and articulation. As such, it is a guide to the possible presence of learning disabilities or a significant discrepancy between cognitive levels of functioning and levels of academic achievement.

Axis III includes any medically-related disorders or conditions which might be affecting the emotional status of the child. Because child psychiatrists are medical professionals, this axis represents a professional finding that can be considered in the SED classification process.

Axis IV is used to identify the psychosocial stressors that may be influencing the emotional stability of the child. They provide clear behavioral indices that can be used to gauge the transient or on-going nature of the emotional disorder. This axis is important also since an emotional disorder which occurs in the absence of such stressors is potentially more serious than the same disorder occurring in the presence of significant stress.

Axis V is used to identify the highest level of adaptive functioning achieved by the child in the past year. Again, this axis provides clear behavioral indices that can be utilized by the school staff to measure the adaptive behavior of the child. This axis also has prognostic significance, since children tend to return to their previous level of adaptive functioning following the termination or diminuation of their emotional disturbance.

In conclusion, while a DSM-III multi-axial diagnosis can be of use to the IEP team in its efforts to make an accurate SED determination, the use of such diagnoses should be considered only one potential indicator of emotional disturbance and should never be utilized alone as an "automatic" definer of serious emotional disturbance under PL 94-142 criteria.

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APPENDIX A

EDUCATIONAL AGENCIES PARTICIPATING IN THE SED CRITERIA PROJECT

ABC Unified School District
Anaheim Elementary School District
Antelope Valley Union High School District
Bakersfield City Elementary School District
Baldwin Park Unified School District
Ballard Elementary School District
Barstow Unified School District
Beverly Hills Unified School District
Central Elementary School District
Chula Vista City School District
Claremont Unified School District
Carpinteria Unified School District
Chino Unified School District
Coachella Valley Unified School District
Conejo Valley Unified School District
Del Mar Union Elementary School District
Desert Mountain Special Education Local Plan Area
Desert Sands Unified School District
Duarte Unified School District
East County Special Education Region
East Valley Special Education Local Plan Area
El Monte Elementary School District
El Segundo Unified School District
Elsinore Union High School District
Escondido Union Elementary School District
Fullerton Elementary School District
Fullerton Union High School District
Garden Grove Unified School District
Garvey Elementary School District
Hacienda La Puente Unified School District
Hueneme Elementary School District
Imperial County Office of Education
Julian Union Elementary School District
La Mesa-Spring Valley School District
Lemon Grove Elementary School District
Long Beach Unified School District
Los Angeles County Office of Education
Los Angeles Unified School District
Manhattan Beach City Elementary School District
Menifee Union Elementary School District
Montebello Unified School District
Moreno Valley Unified School District
Morongo Unified School District
Muroc Unified School District
Newhall Unified School District
Newport-Mesa Unified School District
North Inland Special Education Region

North Orange County Special Education Local Plan Area
Ocean View Elementary School District, Huntington Beach
Ojai Unified School District
Oxnard Unified School District
Palos Verdes Penninsula Unified School District
Paramount Unified School District
Pleasant Valley Elementary School District, Camarillo
Rialto Unified School District
Riverside Unified School District
Rowland Unified School District
Saddleback Valley Unified School District
San Diego City Unified School District
San Diego County Office of Education
San Dieguito Union High School District
San Jacinto Unified School District
San Luis Coastal Unified School District
San Marcos Unified School District
San Ysidro Elementary School District
Santa Barbara High School District
Santa Maria Elementary School District
Santa Monica-Malibu Unified School District
Santee Elementary School District
Sierra Sands Unified School District
Simi Valley Unified School District
South Bay Union High School District
South West Special Education Local Plan Area
Sweetwater Union High School District
Tehachapi Unified School District
Temple City Unified School District
Torrance Unified School District
Tustin Unified School District
Ventura County Superintendent of Schools Office
Ventura Unified School District
Victor Valley Union High School District
Vista Unified School District
West End Special Education Services Region
West Orange County Consortium for Special Education
Westside Union Elementary School District
Whittier Area Cooperative Special Education Program
William S. Hart Union High School District
Yucaipa Joint Unified School District

APPENDIX B

BEHAVIORAL CHARACTERISTICS IDENTIFIED BY PARTICIPATING EDUCATIONAL AGENCIES AS COMPRISING EVIDENCE OF SERIOUS EMOTIONAL DISTURBANCE

The following behavioral characteristics were identified by LEAs participating in the DSNHC-SC survey project as comprising evidence of serious emotional disturbance. In most cases, these characteristics were not broken down by legal category. The list below arbitrarily places LEA-identified behaviors into the five SED categories which appeared most appropriate to DSNHC-SC staff when reviewing the data.

It should, of course, be kept in mind that the presence of any particular behavior by itself does not necessarily mean that the child can be validly classified as SED. It should be remembered that only "clusters" of behaviors, taken into consideration with other assessment variables and sources of information, can provide valid information in this regard.

The California Association of School Psychologists (1984) undertook a more limited selection of behavioral characteristics from 24 LEAs. Using only descriptors which fell above a certain criterion score (number of LEAs who identified that descriptor), the CASP project was able to identify a number of specific descriptors which they felt validly operationalized five SED legal categories. The descriptors identified by the CASP project are identified by an asterisk (*) next to the descriptors listed below.

No claim is made as to the validity of the behaviors listed below, and it should be noted that there is often unclear discrimination among listed behaviors. However, no descriptor was listed unless at least five LEAs identified the same or similar descriptors as comprising evidence of a serious emotional disturbance.

I. AN INABILITY TO LEARN WHICH CANNOT BE EXPLAINED BY INTELLECTUAL, SENSORY OR HEALTH FACTORS

-Failure on classroom tests or quizzes
-May appear functionally retarded (IQ variable)
-May have superior skills in some areas but no apparent application
-May be at any level of achievement
-Performs daily academic tasks or homework at a failing level
-Academic achievement lower than the instructional range for student's appropriate age and grade
-Failure to (or refusal to) complete class assignments or homework
-Demonstrates difficulty (or reluctance) in beginning academic tasks
-Tends to refuse any activity that appears difficult
-Reduced productivity across all academic tasks
-Variable academic success - may do poorly in one area but perform well in another

II. AN INABILITY TO BUILD OR MAINTAIN SATISFACTORY RELATIONSHIPS WITH PEERS AND TEACHERS

*Has no friends in home, school or community settings
*Is extremely fearful of teachers and peers
*Avoids communicating with teachers and peers
*Does not play, socialize, initiate or engage in recreation with others
*Avoidance of others or severely withdrawn behavior
-Incapable of maintaining interactive behaviors with others
-Avoids interactions with students or teachers
-Views others as objects
-Fails to participate verbally or physically in group situations
-Unresponsive to and unrelated to people
-Pervasive social problems in home and school settings
-Peer relationships short-lived, anxiety-provoking and even chaotic
-Has difficulty in establishing and/or maintaining group membership
-Peers often alienated by intensity of child's need for attention
-Conflict and tension in almost all social relationships
-Forms rapid, intense, engulfing relationships

III. INAPPROPRIATE FEELINGS OR BEHAVIORS UNDER NORMAL CIRCUMSTANCES

*Catastrophic reactions to everyday occurrences
*Extreme mood lability
*Lack of appropriate fear reactions
*Unexplained rage reactions or explosive, unpredictable behavior
*Flat, blunted, distorted or excessive affect
*Manic behavior
*Inappropriate affect (e.g., laughing, crying or displaying anger or fear in inappropriate ways)
*Peculiar posturing
*Bizarre ideas or statements
*Belief that others are conspiring against the student
*Hallucinations (auditory or visual)
*Delusional thinking (e.g., feelings of being controlled, thought broadcasting, persecutory ideas, etc.)
-Demonstrates sudden or dramatic mood changes
-Demonstrates behaviors not related to immediate situations (e.g., laughs or cries without reason)
-Has unrealistic plans for self
-Excessive or inappropriate feelings of doubt or guilt
-Repetitive, ritualistic, stereotyped motions
-Distorted use of body or bodily parts
-Marked illogical thinking, incoherence, loosening of associations or magical thinking
-Disorientation in time or place
-Lack of contact with reality
-Excessive or unnecessary body movements
-Involuntary physical reactions
-Self-stimulatory behaviors
-Non-human quality to actions or behaviors
-Habitual confusion

-Reality sense is distorted without regard to self-interest
-Inability to adapt or to modify behaviors to different situations

IV. GENERAL PERVASIVE MOOD OF UNHAPPINESS OR DEPRESSION

*Fails to demonstrate an interest in special events or interesting activities
*Loss of interest in usual activities
*Prominent and persistent feelings of depression, hopelessness, sadness or irritability
*Insomnia or hypersomnia
*Excessive fatigue or loss of energy
*Poor appetite or significant weight loss
*Feelings of poor self-worth
*Exhibits unwarranted self-blame or self-criticism
*Inadequate self-concept (e.g., blames self for inadequacies, real or imagined)
*Engages in self-destructive behavior
*Recurrent thoughts of death or suicide
-Fails to demonstrate a sense of humor when appropriate
-Makes verbal statements of unhappiness or depression
-Lack of capacity for pleasure
-Rarely experiences truly satisfied feelings
-Has trouble giving or receiving affection
-Outbursts of overactivity

V. TENDENCY TO DEVELOP PHYSICAL SYMPTOMS OR FEARS ASSOCIATED WITH PERSONAL OR SCHOOL PROBLEMS

*Physical symptoms without organic findings
*Persistent irrational fears resulting in avoidance of a specific object
-Panic reactions
-Complaints of physical discomfort
-Child is intensely and generally anxious and fearful

Participating LEAs also identified the following behaviors (which appeared more indicative of behavioral disturbance than serious emotional disturbance) as characteristic of a serious emotional disturbance. However, it should be remembered that such behavioral indicators may be reflective of internal distress, and further evaluation and assessment should be undertaken to determine whether a serious emotional disturbance is in fact present.

AGGRESSION
-Makes derogatory comments or inappropriate gestures to others
-Takes things that belong to others
-Blames others or materials for own failure or difficulty
-Does not obey teachers' directives or classroom rules
-Deliberately makes false statements (persistent, deliberate)
-Uses obscene or profane language
-Makes inappropriate noises
-Destroys property (e.g., books, lockers, etc.)
-Difficulty complying with adult authority
-Can be destructive to property without remorse

CONDUCT DISORDER
- -Has no consistent internal value system
- -Truant
- -Rebellious towards authority
- -Mistrustful of others
- -Runaway
- -Must have immediate gratification
- -Needs immediate rewards
- -Disregards consequences to self
- -Blames others for failures or difficulties
- -Engages in inappropriate sexually related behaviors
- -Is absent or tardy without legitimate reason
- -Is preoccupied with drugs or alcohol or uses them at school

INADEQUACY/IMMATURITY
- -Intense need for attention
- -Over-reliance upon adults
- -Lack of independence

LANGUAGE
- -Context of language often bizarre
- -Uses excessive sexual talk
- -Talks to self
- -Incessant talking, rambling, not conversational
- -Delayed or decreased vocabulary
- -Echolalia
- -Speech disorganized
- -Perseveration on particular object or subject
- -Fragmentation of language
- -Flattened tone
- -Irrelevancy of context
- -Inappropriate rhythm
- -Lack of pragmatic communication skills

DEVELOPMENTAL ISSUES
- *Early onset of problems
- *Delayed developmental milestones
- *Failure to master developmental tasks
- *Marked psychomotor retardation
- *Large gaps in developmental areas

OTHER
- *Previous mental health referrals prior to involvement with school personnel

IMPULSIVITY
- *Exhibits off-task behaviors frequently
- *Careless performance
- *Easily distracted from tasks
- *Poor task completion skills
- *Attention and concentration appear impaired

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